

**Comments on State HIE Proposal**  
**RFC # 201101-01**  
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Obviously, many people have donated vast amounts of time and energy to get the HIE to this point. In an effort to keep their efforts from being made in vain, I would like to offer the following suggestions for improving the plan:

- Do not implement this system until most of the value-added functions are included. The success of the HIE network depends on adoption of electronic medical record systems by clinicians. For most clinicians this means demonstrating HIE as a useful clinical tool that is not a burden to their practice workflow. Without lab data, radiology data, image delivery, medication management, and quality reporting, it will be difficult for a clinician to attain “meaningful use”. If the provider cannot easily use the HIE network to accomplish this, he/she will scrap the system and never come back. The first impression is the most important.
- Don’t pass costs to the provider. I suspect that “value-added” really means “extra cost to the clinician”, and I feel that would be a mistake. In order to even consider using the HIE network, a clinician must have already devoted large amounts of time and money to incorporating electronic health records into the practice of medicine. Any additional fees for using the full functionality of the HIE network would be viewed as outrageous by most clinicians. In fact, given the cost of obtaining, storing, and categorizing the information necessary for physician participation in the HIE network, the network should be paying clinicians to provide that information.
- Implement an “opt-in” format for the network. Extensive discussion with patients is necessary to explain the nuances of participating in such a network, whether opt-in or opt-out is deployed. Thorough disclosures of the risks to privacy as well as the benefits of participation are necessary in either case. If that information has been properly explained to the patients, then the rates of participation should be the same with either option. The “opt-out” option has the disadvantage of deceiving some patients into participating when they might have opted out if they knew the full implications of their decision. Furthermore, the “Opt-out” option has the potential to allow complaints from individuals who were unaware that their information was being shared. The “opt-in” format is better because it demands direct patient participation and effort to implement health information exchange. Patients are used to signing release forms and HIPAA papers with every physician, so it is not a shock for them to have to sign one more consent form.
- Message routing is important. Most office charts are now transferred by mail or fax, after request by another provider of health care entity. Since every EMR system has the capability of creating a report in a printable format, the HIE should allow secure transfer of reports in a standard format such as .PDF or .doc so that providers can communicate with each other.
- Formats containing structured text such as CCD and CCR are equally important, as they allow clinicians to seamlessly populate their patient information from other sources. This saves time and effort, and is a benefit to the clinician.
- I would urge you to view all medical information as either *static* or *dynamic* in nature. *Static* data, or data that does not change with time can be shared through the network as unstructured text. Examples of this would be operative notes, radiology reports, and encounter notes. Once completed they do not change. *Dynamic* information, or information that changes with time should be in structured format that can be easily transmitted and analyzed. Lab data, vital signs, and monitored data such as an audiogram would be examples of dynamic data that changes rapidly and requires comparison with previous measurements. Demographic data is a type of dynamic data that changes slowly (people move or get new phone numbers and insurance carriers, etc.). Keeping track of what type of data is being handled can ensure that the optimum format is used for exchange.

- Require clinician permission for each episode of static information sharing unless an emergency “break glass” status is declared. Even with authorization, a provider or analyst should NEVER be allowed to enter into another providers record system and access records. Audit trails are not a substitute for permission. The provider must know that there has been a request, who has made that request, and why the request was instituted before any records are released. It must require an active response by the provider whose patient records were requested before transfer can occur. Patient information should never be accessed through a HIE network through a “back door” unknown to the clinician. If this ever occurs, clinicians will lose confidence in the HIE network, and the patient-physician confidentiality relationship will be jeopardized.
- I am concerned that aggregated data will be extracted from the HIE without clinician knowledge or participation. The source of any aggregated data should be accumulated at the level of the provider, sorted and placed into the proper format for the study, de-identified, then submitted. It should not be extracted from the HIE network without clinician participation and knowledge.
- I would add that there needs to be some type avenue for a participating provider to determine which aggregated data will be made available to the network for research and commercial purposes. Since insurance carriers store much of their claims data in secret as proprietary data, it is unfair for them to have access to aggregate clinical data on the HIE network for commercial use without sharing all of their claims data with the HIE network. If providers do not have access to proprietary claims data for cost and clinical analyses, then commercial entities that wish to analyze data for commercial use should be required to pay for it, and that money reimbursed to the clinicians who provide aggregate data to the HIE network.